STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011437	A. BUILDING: _____ B. WING _____	10/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL NORTH	7150 CLEARVISTA DR INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS Surveyor: 33212 Facility Number: 011437 Type of Survey: State Licensure Off Site JCAHO Accreditation Survey Date of JCAHO On Site Survey - Hospital full survey 10/7-11/2013 Date of ISDH off site review - 6/11/2014 Reviewer/Surveyor -Nancy Otten, RN, PHNS Based on review of the January 13, 2014 JCAHO Accreditation Survey Report, it has been determined that Community Hospital North meets the requirements for Hospital Licensure in Indiana for 2013.	S 000		